

DOCUMENT RESUME

ED 261 281

CG 018 479

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TITLE Adolescent Suicide Awareness Training Manual.
INSTITUTION New Jersey State Dept. of Education, Trenton.
REPORT NO PTM-400-18
PUB DATE May 84
NOTE 58p.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Adolescent Development; *Adolescents; Community Resources; *Helping Relationship; *High Risk Persons; Identification; *Intervention; Mental Health Programs; *School Personnel; Secondary Education; *Suicide

ABSTRACT

This training manual is intended for use by school personnel, especially at the secondary school level, who must deal directly with suicidal behavior among students. Guidelines are presented for dealing with the reactions of a school system to an actual suicide and for dealing with the return to school of a student following a suicide attempt. An overview of adolescent suicide is provided which includes a statistical profile of adolescent suicide and brief discussions of 15 myths about suicide. Some crises experienced in puberty and adolescence are discussed. This manual is not designed to train school personnel to treat the suicidal adolescent, but rather to aid personnel in the identification of students who may be suicidally prone. An intervention approach is described which, beginning with identification of at-risk students, moves on to suggest ways of: (1) linking these students and their families to appropriate mental health and community resources; (2) working with the parents and the community; and (3) working with the students in an educational context. A four-page bibliography of recommended books, journal articles, and film strips is included.
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ADOLESCENT SUICIDE AWARENESS TRAINING MANUAL

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ADOLESCENT SUICIDE AWARENESS TRAINING MANUAL

SAUL COOPERMAN
COMMISSIONER OF EDUCATION

NEW JERSEY STATE DEPARTMENT OF EDUCATION
225 WEST STATE STREET
TRENTON, NEW JERSEY 08625
MAY 1984

PTM 400.18

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Acknowledgements

We wish to express our deep gratitude to the following professionals for the development and preparation of this training manual:

Dr. Yetta H. Appel, Professor, School of Social Work, Rutgers, The State University of New Jersey, and Mr. Abraham Matus, School Psychologist, Ridgewood School District, who not only served as consultants to the New Jersey Adolescent Suicide Awareness Project, but also assumed major responsibility for developing the content of the manual. As part of this responsibility, the following professionals were recruited to write selected sections of this manual, and their contributions are most gratefully recognized:

Karen Maxim, R.N., M.S., Community Mental Health Center and Rutgers Medical School, University of Medicine and Denistry of New Jersey; section on "Family Considerations;"

Dr. Stanley F. Winters, Associate Professor, Queens College, City University of New York, and Clinical Psychologist, Ridgewood, New Jersey; section on "Puberty/Adolescence and Its Crises; and Henry P. McNally, Director of Guidance, Ridgewood School District, Ridgewood, New Jersey; section on "School Policies, Guidelines, Procedures."

Additionally, we wish to express our sincere appreciation to: Samuel B. Stewart, Superintendent, Ridgewood School District, New Jersey who enabled Mr. Matus, through released time, to participate in the development of the project and the preparation of this training manual.

A special acknowledgement is extended to Geraldine Parham of the Division of Special Education who initiated this project because of her genuine concern for troubled teenagers in New Jersey and for the professionals who are working to assist them.

Carol N. Scelza
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INTRODUCTION

It can be said to be a sign of the times that this training manual has been developed under the aegis of the New Jersey State Department of Education. This division of New Jersey's state government has been, in many ways, closest to the alarming social problem of adolescent suicide. High school and junior high school teaching staff, school guidance personnel, nurses, administrative staff, and child study teams have increasingly had to face students entering puberty (in middle and junior high schools), or who are in the adolescent stage (senior high school) who have shown suicidally prone behavior, and/or have actually committed suicide.

Suicidal behavior, and/or the act of suicide, frightens and disorients professionals and lay-persons alike. Life, almost universally, is seen as a precious and sanctified gift. How, then, is it possible for young people, especially those on the threshold of taking charge of their own lives, to want to end their lives even before they have truly begun? This is the paradox of adolescent suicide, and this needs to be better understood, particularly by school personnel who can be in a highly strategic position to reduce it.

This training manual aims at sensitizing and desensitizing school personnel. In presenting factual knowledge, statistics, and information that is currently understood about adolescent suicidal behavior, it may help to reduce some of the insecurity, helplessness and anxiety felt by those who have to deal directly with suicidal behavior among students. At the same time, there is a need to sensitize relevant school personnel and teaching staff to this problem, so that school systems can provide appropriate kinds of support and services within New Jersey.

It is further emphasized that this training manual is primarily concerned with heightening awareness - "raising consciousness," if you will. From the outset, it has been recognized that school system personnel cannot be expected to treat the suicidal adolescent. Rather, they need to recognize that they are in a position to aid in the identification of those young people who may be suicidally prone, and to intervene in order to link these young people and their families to treatment programs in the community. In addition, school personnel need to be better prepared to sensitively relate to suicidal young people following a suicide attempt, and to deal with the intense emotions/reactions of the school community following an actual suicide. These are the basic objectives of the Adolescent Suicide Awareness Training Program and the training manual.

This training manual contains an overview of adolescent suicide; puberty-adolescence and its crises; identification of potential high risk pupils, parental/family involvement; community resources and outreach; intervention and follow-up re: suicidal acts; the school system's response following a suicide and resource materials available to trainers.

This introduction concludes with a glossary of terms, as there is considerable confusion and miscommunication surrounding descriptions of various aspects of suicidal behavior. To avoid this, the following definitions are offered for use in this training manual:

- Completed suicide - when someone takes his/her life with conscious intent
- Attempted suicide - includes all of the elements of a completed suicide (i.e., doing something that one believes will cause death); having the conscious intent to die but not dying. (Usually, attempters remain alive due to circumstances beyond their control.)
- Suicidal gesture - an act that is symbolic of suicide, but which constitutes no serious threat to life; an act of such low probability of being fatal or deadly that it is obvious that no serious intent to die is present.
- Suicidal threat - saying or doing something that indicates a self-destructive desire. (Many threats are made with no follow-through and/or no serious intent by people who see no way out of a problem and are merely asking for help. Because it is sometimes difficult to distinguish serious threats from idle threats, all threats should be treated as though they are serious until there is certainty that they are not.)
- Suicidal ideation - having thoughts about killing oneself. (Almost everyone has such thoughts at some time.)
- Subintentioned death - playing a covert or subconscious role in bringing about one's death by placing oneself in an extremely vulnerable position (e.g., a victim-precipitated homicide).

IMPACT OF SUICIDE ON SOCIETY

In order to be able to respond appropriately to this social problem and, more importantly, to intervene effectively, adolescent suicide needs to be viewed within a societal context. In American society, suicide appears to be disproportionately manifested among our youth and our elderly - two populations who are likely to have greater feelings of vulnerability and powerlessness, and who tend to feel less in control of their lives. Youth - because they are still in a dependent state, and cannot exercise, as yet, the privileges associated with adult status; the elderly - because they are experiencing a slipping away of their taken-for-granted independence, their adult prerogatives and their looming dependency due primarily to physical decline which may include debilitating physical illness. In point of fact, the highest rates of suicide in the United States are found among the elderly, not among adolescents. This is a most poignant commentary as to the quality of life actually experienced by our elderly population.

Although the adolescent suicide rate may be lower when compared with that of the elderly, the rate for youth nationally has been increasing, and markedly so for youthful males. In the age group 15 to 24 years, the rate doubled for white males in the years from 1950 to 1970, increasing from 6.6 per 100,000 population in 1950, to 13.9 per 100,000 in 1970. In the same time period, the rate for non-white males increased from 5.3 per 100,000 to 11.3 per 100,000 population. For white females, there were 2.7 deaths by suicide per 100,000 population in 1950 compared with 4.2 per 100,000 in 1970, while for non-white females the rate in 1950 was 1.7 per 100,000 and in 1970, 4.1 per 100,000 population.¹

Viewed within a societal context, these increases may well reflect the impact of greatly accelerated social changes and social unrest. Young people approaching maturity today may be subject to levels of social stress and social alienation that appears to be qualitatively different from that experienced by youth two or three decades ago.

Statistics reveal further that more suicides among young people are occurring at younger ages, i.e., in the pre-adolescent stage and under the age of eleven. This increase has occurred only in the last five years along with a significant increase in diagnosed childhood depression.

QUESTIONS AND CONCERNS

In general, those providing training in suicide awareness need to be particularly attentive to the questions, explicit and implicit, that many school personnel have about suicide, and suicide prone young people. By and large, when we are confronted with suicidal behavior, or suspected suicide attempts, there is almost always the underlying question, "Why? Why would someone want to do away with his/her one and only life?" And if this victim is an adolescent, "Why before his/her life has even begun?"

As one thinks further about the behavior, the question may arise as to whether suicidally prone people are "like us," and whether this could possibly happen in one's own family, to one's own neighbors, friends or friends' children. Trainers need to be aware that suicide and suicidal behavior bring to the fore feelings about the termination of life in general. Most people tend to distance themselves from death-related feelings and "deny" them. This is especially true with regard to one's own mortality, as the work of Elizabeth Kubler-Ross has demonstrated.² It is important in focusing on the development of greater awareness of adolescent suicidal behavior, feelings and ideation to be sensitive to the discomfort and possible anxiety that may arise, for trainees are being asked to deal with the fact of death and death-related phenomena.

The focus on youthful death can be even more disturbing, since it seems to be "out of order" generationally. Given the marked reduction in infant mortality, improvement in child health practices and availability of sophisticated medical care, we do not expect in our society to have children and adolescents die. This is more acceptable in old age. Thus, suicidal death may reinforce the sense that our own hold on life may be fragile and ephemeral.

In addition to being alert to these kinds of generalized reactions, school personnel are also likely to raise questions related to their functional responsibility while serving as teachers, guidance counselors, administrators, nurses, etc. Essentially, these questions are likely to be:

- What is the overall responsibility of a school system and its personnel with regard to possibly suicidally prone students?
- What is the degree of individual responsibility on the part of school professionals?
- What do I need to know about suicide and related behavior as a school professional?

Further, one needs to be prepared for questions such as:

- Should schools "oversee" emotional instability in students?
- Is one a teacher, or a therapist?
- Is the "impersonality" of school systems somehow related to disturbed and/or stressful behavior and to suicidal acting-out in students?

- May the increasing impersonality be an indication that concern for one another is fading from our society?
- Does the school ever contribute to a suicide, or are the reasons usually deeper?
- Can there be a chain reaction of suicides?
- Could a school system and its personnel help to reduce the incidence of suicide attempts?
- What are the legal considerations if school systems and/or their personnel do or do not intervene?

Other questions that are likely to be asked are:

- Are there ways of identifying those who may be at risk earlier?
- What can one do on a daily basis?
- When and how should one intervene?
- Besides reporting a suicidal student to a trained professional counselor, are there specific approaches that I can use which may help?
- Are there optimal ways of handling students following a suicide (e.g., class discussions, individual conferences, etc.)?
- Are there ways that I can alleviate undue tension and/or pressures among my students?

With regard to knowledge and/or attitudes about suicide and suicidal behavior, school professionals are likely to be concerned about:

- Whether there is a relationship between abuse of drugs and alcohol and suicidal attempts;
- Whether a suicidal attempt indicates that the youngster is mentally ill;
- If there are possible discernible factors and/or situations that can lead to a suicide attempt;
- Whether there are common denominators in the backgrounds of suicidal adolescents;
- Whether students successfully conceal suicidal tendencies -- or, is it that we do not pay attention to the clues that are given;
- The seriousness with which one should take "suicidal talk;"

- The degree to which a student's talk about depression and/or suicidal feelings is real or an act for attention.

Trainers may not be able to answer all of these kinds of questions or respond to these concerns, but it is helpful to elicit such questions and concerns as a way of defusing some of the attendant anxiety and discomfort that trainees may be experiencing. Being able to raise questions may help reduce some of the "pluralistic ignorance" that group members bring; i.e., members may think that they are the only ones who do not "know" these things. For effective inservice programs, trainers should be aware of the types of concerns that school professionals are likely to have, and how to respond to these concerns knowledgeably and sensitively.

A Statistical Profile

Understandably, one of the major concerns regarding youthful suicide is the extent of the problem. For example, how many youthful suicides occur annually, and how are they distributed by age, sex, race, socioeconomic status and religion? Given the societal taboos and stigma surrounding suicide, it is not surprising to find that official statistics tend to be fragmented and incomplete. Also, the reliability of these statistics continues to be questioned. Among those who compile our vital statistics, there is unanimity that statistics on suicide are probably grossly under-reported.

The statistics that are gathered report only completed suicides. However, there are deaths classified as accidents and/or homicide which medical examiners suggest may well be suicides. In addition, suicide attempts, which by far are more numerous, are not systematically recorded within the states or nationally. Edwin Shneidman, one of this country's foremost suicidologists, has stated: "Because of religious and bureaucratic prejudices, family sensitivity, differences in the proceedings of coroners' hearings and postmortem examinations, and the shadowy distinctions between suicides and accidents -- in short, the unwillingness to recognize the act for what it is -- knowledge of the extent to which suicide pervades modern society is diminished and distorted."³

According to the 1980 edition of the Statistical Abstract of the United States,⁴ nearly 30,000 Americans ended their lives by suicide. Suicide ranked among the top five causes of death for white males aged ten to 55, and was the second ranked cause of death for all males aged 15 to 24. Females are five to ten times more likely to attempt suicide than males; but males are more likely to succeed at suicide. It is further estimated that about one million suicide attempts occur annually in the United States, and that about 12 percent of these attempts are made by adolescents. This estimate, however, may be only the "tip of the iceberg" with regard to the actual occurrence of suicidal attempts and gestures.

Where does New Jersey stand in comparison to the United States? This section provides a statistical profile of youthful suicide in New Jersey. Suicide is not one of the 10 leading causes of death for New Jerseyans. Further, suicide in New Jersey occurs with the greatest

frequency in the age group 25 to 44, and according to the annual mortality statistics for 1981⁵, is also higher in actual numbers in the age groups 45 to 64, and over 65 than adolescent suicide. (The latest available statistics from the New Jersey Department of Health are for 1981.)

As is true for the United States, accidents are the leading cause of death for the 15 to 24 age category in New Jersey, and accidental deaths within this age group are of great concern nationally, as well as in New Jersey. In 1981 in New Jersey, there was a total of 1,313 motor vehicle accidents for all age groups. The largest proportion, 32% was in the 15 to 24 age group. For all accidents reported in New Jersey for 1981, 23% (2,741) occurred in the 15 to 24 age group.

With regard to suicidal deaths, it may be helpful to compare the figures for 1981 with those of 1978 in order to develop a better perspective. Table I provides some comparative figures.

TABLE I
Selected Statistics on Youthful Suicide
in New Jersey, 1978 and 1981*

<u>Suicide Statistic</u>	<u>1978</u>	<u>1981</u>
No. of Suicides in 5 to 14 Age Group	4 (2 male; 2 female)	7 (All male)
No. of Suicides in 15 to 24 Age Group	99	92
Ratio of Male to Female Suicides for 15 to 24 Age Group - Both sexes	3:1	9:1
Ratio of White to Non-white suicides for 5 to 14 age group - both sexes	3:1	6:1
Ratio of White to Non-white Suicides for 15 to 24 Age Group - Males**	9.7:1	8.3:1
Ratio of White to Non-white Suicides for 15 to 24 Age Group - Females	9.3:1	9:0

*Statistics for 1981 secured from Health Data Services, Division of Health Planning and Resources Development, New Jersey State Department of Health. For 1978, the Annual Report on Mortality Statistics for the State of New Jersey was utilized.

**In 1978, the designation "non-white" was used, but apparently referred entirely to the Black population. In 1981, the designation, "Black," is used, and they constitute the non-white group. Statistics on suicide do not include data on the individual's religion or socioeconomic status.

The 1978 age-specific rate of suicide for the 15 to 24 group per 100,000 population in New Jersey was 8.0; for 1981, it was 7.2 per 100,000 population. This compares favorably with the 1981 age-specific rate for the 15 to 24 age group of 13.0 per 100,000 population for the United States as a whole. For both years, accidents were the leading cause of death in the 15 to 24 age category, and suicide was the third leading cause. Although the age-specific rate is lower for New Jersey than for the country as a whole, this should not invite complacency. It still represents almost 100 youthful deaths, a good many of which might have been prevented through timely and sensitive intervention. Furthermore, the rate is undoubtedly an underestimate, given the statistics on accidents for this age category.

Suicidologists have suggested that some accidental deaths are subintentioned deaths, i.e., the individual plays some part, often subliminally and unconsciously, in his/her death. If one reviews the causes for accidental deaths for 1981 for the 15 to 24 age category, one finds that there were 18 poisonings (gas excepted), 11 deaths by falls, and ten by firearms. Within the category of motor vehicle accidents for this age group, two deaths were due to a collision with a railroad train, 162 with another motor vehicle, 12 with a fixed object, and 165 deaths were the result of noncollision. Until the statistical information in this area becomes more reliable, it is hard not to assume that an unknown proportion of these accidental deaths were really suicidal in intent.

In the comparison of 1978 and 1981 occurrences of suicide, there is a definite increase in the number of suicides in the 5 to 14 age category, and this appears to reflect a national trend. The National Institute of Mental Health has noted a disturbing increase in childhood and early adolescent suicide. For New Jersey, the sex difference is certainly evident, but what may be more alarming is the three-fold increase in 1981 in the number of male suicides as compared with female suicides. Further, all of the suicides in the 5 to 14 age group in 1981 were male. The data suggest that young pre-adolescent and adolescent males appear to be more vulnerable to death by suicide than appears to be the case in the recent past. According to the data, this is apparent for both white and non-white males.

As for race, in 1978, suicide was the second leading cause of death for white males, and the third leading cause for white females. For non-white males, homicide was the second leading cause, and suicide was fifth. For non-white females, homicide was fourth and suicide was not one of the five leading causes of death. In 1981, the race difference is more marked in that there are no female black suicides for the 15 to 24 age category. The ratio of white to black suicides for males in 1981 shows a slight decrease for white males, but the difference is still substantial.

+An age-specific rate is an age-adjusted death rate in which the number of deaths for that age category, is compared to the total number of individuals in that age category instead of to the United States population as a whole.

The data for New Jersey are similar to that of the country as a whole, i.e., suicides occur disproportionately among whites for both sexes, and that within the black group homicide accounts for more deaths than does suicide.

Some suicidologists assert that an unknown, but considerable proportion of homicidal deaths among blacks are subintentioned deaths. In addition, there is some evidence that the rate of suicide for black adolescent males may be increasing nationally. In a September, 1981 article in Ebony magazine,⁶ it was reported that although the National Center for Health Statistics of the U.S. Department of Health and Human Services does not list specific ethnic groups, it did find that from 1968 to 1978, the suicide rate for non-white ages 5-14 increased 200 percent, from 0.1 suicides per 100,000 population to 0.3 per 100,000. Among non-whites aged 15 to 24, the rate increased 59 percent, from 5.6 suicides per 100,000 population in 1968 to a 1978 rate of 8.9. Given the disproportionate sex ratio in both the white and non-white groups re: completed suicides, it is clear that the increase in both of these groups, as reported by the National Center for Health Statistics, basically documents the increase in suicide for black adolescent males. It may also be that the 8.3 to 1 ratio for white to non-white male suicides reported in Table I reflects this trend among black adolescent males in New Jersey.

New Jersey also records the number of suicidal deaths by county. Table II ranks the 21 counties in New Jersey by their overall suicide rate, and the age-specific rate for the 15 to 24 age category.

TABLE II

Ranking of New Jersey Counties re: Overall suicide Rate and Age-Specific
15 to 24 Rate for 1981

Category I		Category II	
Overall Suicide Rate Per 100,000 Population, 1980 Census Data		Rate Per 100,000 Population, Aged 15 to 24, 1980 Census Data	
County	Rate	County	Rate
Ocean	12.4	Cumberland	17.4
Salem	10.8	Camden	12.0
Morris	10.5	Morris	11.5
Hunterdon	9.2	Ocean	10.6
Camden	9.1	Middlesex	9.1
Sussex	8.6	Salem	9.1
Cape May	8.5	Cape May	7.7
Gloucester	8.5	Monmouth	7.1
Cumberland	8.3	Burlington	7.0
Middlesex	8.2	Hunterdon	7.0
Monmouth	7.9	Essex	6.7
Atlantic	7.7	Passaic	6.3
Burlington	7.7	Atlantic	6.1
Mercer	7.1	Somerset	5.7
Bergen	6.6	Gloucester	5.3
Hudson	6.5	Hudson	5.1
Somerset	6.4	Mercer	5.1
Warren	5.9	Bergen	5.0
Essex	5.8	Union	4.7
Union	5.6	Sussex*	---
Passaic	4.9	Warren**	---

*In Sussex County, there were no suicides in the 15 to 24 age group in 1981, but there was one suicide in the 5 to 14 age category.

**In Warren County, there were no suicides in either the 5 to 14 age group, or 15 to 24.

As is evident, the two categories are not necessarily related, but it is apparent that suicide occurs in highly affluent areas of the state, as well as in socio-economically less advantaged communities; in rural sections as well as in densely populated urban centers. Further, in six counties, Cumberland, Camden, Morris, Middlesex, Essex and Passaic the age-specific rate for the 15 to 24 age group was larger than the overall suicide rate for that county. Although in the remainder of the counties the rates were either practically equivalent or smaller, it is evident that a great deal more needs to be done in New Jersey to reduce these rates even further.

Table III gives the actual number of suicides in 1981 by county for the 15 to 24 age group, together with the county population for this age group as recorded in the 1980 census. The rates in Table II were calculated based on these figures.

TABLE III

Number of Adolescent Suicides in 1981 by County and Population
in 15 to 24 Age Group in 1980 Census

<u>COUNTY</u>	<u>NO. OF SUICIDES</u>	<u>15 to 24 Population (Base)</u>
Atlantic	2	33,051
Bergen	7	140,072
Burlington	5	71,941
Camden	10	83,612
Cape May	1	13,066
Cumberland	4	23,051
Essex	10	143,574
Gloucester	2	37,627
Hudson	5	98,057
Hunterdon	1	14,381
Mercer	3	58,929
Middlesex	11	120,343
Monmouth	6	84,442
Morris	8	69,801
Ocean	5	47,298
Passaic	5	79,044
Salem	1	10,948
Somerset	2	35,174
Sussex	1	--
Union	4	84,555
Warren	1	--

Suicide in youth is preventable. With greater knowledge, awareness, training and communication, more such acts can be reduced.

Search for Explanations

As hard as it may be to accept, we need to recognize that suicide is exclusively a human act, and has been an integral part of human history and human development. Seneca, the Roman, stated, "Against all the injuries of life, I have the refuge of death." When viewed historically and cross-culturally, we find that suicide has not always been seen as a negative, needlessly self-destructive act. In a number of cultures (Japan being a notable modern example), suicide has been socially sanctioned as a way of dealing with human frailties, and errors, stigmas of various kinds, declining social competence, or reduction in social value.

Historically, too, there has been the human need to search for explanations. Certainly, within modern society whenever a suicide occurs, there is a kind of "social autopsy" (in addition to a "psychological autopsy" of an individual case by suicidology professionals) in which the social context is examined in order to understand why this act occurred in this particular time and place. This kind of searching inevitably confronts us with what is best and worst about our society. We seem to need to find rational reasons for what many have come to view as an irrational act. In many instances, a "scapegoat" will be sought in order not to look too closely at ourselves and our society.

At the same time, there has also been evident the human tendency to "hush up" suicidal acts, to keep them in the "closet." This "conspiracy of silence" - this lack of open communication has engendered many myths and fallacies about suicidal behavior which need to be separated from scientifically based social-psychological theories, and systematically debunked. A number of suicidologists now suggest that given appropriate circumstances almost anyone can be suicidal.

The modern study of suicide has essentially followed two perspectives: (1) a sociological model based on the work of the French sociologist, Emile Durkheim, and (2) a psychological model utilizing a psychoanalytic framework stemming from the work of Sigmund Freud. Each of these perspectives offers a coherent framework, typically based on direct observation of human behavior, within which an understanding of suicidal behavior becomes possible.⁷

In the sociological model, the focus is on the relationship between the individual and society. According to Durkheim, an integrated social situation is one in which the individuals comprising a society, or social group, are basically attached to the society's governing rules through moral obligations and/or the statuses by which they are linked to the society. Suicide occurs as a result of disturbance in the ties between the individual and society. Durkheim also postulated three types of suicide; anomic, egoistic, and altruistic.

Anomic suicide occurs when the relationship between an individual and the society is suddenly shattered due to some trauma or catastrophe. The usual standards of social conduct may be weakened, and the person is viewed as being in a state of anomie. Because of the disruption of the ties to social groups, or society, the individual may become anxious, disoriented, isolated, and experience considerable loneliness. The anomic event is usually a severe loss. In fact, any sudden and disruptive change, whether it is perceived as positive or negative, might precipitate an anomic suicide. Durkheim emphasized that given the disruptions characterizing Western societies, such as economic hardships, divorce, increasing mobility, etc., that anomic suicide may well be a chronic condition. It may be that adolescents in our society who are experiencing, in general, greater social stresses and social disconnectedness are particularly vulnerable to anomic suicide.

Egoistic suicide refers to suicide that occurs when an individual's mental state shows rather extreme preoccupation with the self. For such an individual, there may be little integration between the person and the family or other social groups, and the person may show little concern for the community's values and/or social sanctions. Thus, society's sanction against self-destructive behavior tends not to deter the egoistic suicide.

Altruistic suicide, the third form in Durkheim's typology, results from an excessive integration of the individual with society. The group's values can take over and almost completely dominate an individual's behavior. The mass suicide which occurred in Jonestown is an example of altruistic suicide. The moral beliefs of this community were able to influence many of the individual adherents to commit suicide.

In contrast to the sociological model, the psychological perspective focuses on intrapsychic pressures impelling a person toward self-destruction under conditions of enormous stress. Freud postulated that the psychological process of identifying oneself with an admired person, particularly one on whom one may be dependent, characteristically involves a high degree of ambivalence. This refers to the phenomenon that one can have feelings of love alternate with feelings of hate directed to the same person.

In the case of suicide, when the self is frustrated, the aggressive, negative component of the ambivalence is aimed at the "internalized" person, i.e., the internal "image" of the person with whom the self has become identified. Thus, self-destructive behavior may really not be directed against the self, but rather the "internalized" person, image, or object towards whom ambivalent feelings predominate. Through suicide, the source of frustration, which is felt to be the internalized object that is ambivalently loved and hated, is eliminated. In the psychoanalytic model, suicide is linked with homicide.

Karl Menninger^a has further elaborated this perspective by stressing that a suicidal person typically may wish to kill and/or may wish to be killed. Underlying both these wishes, however, may be the wish to die. Menninger believes that suicide involves strong, unconscious hostility combined with a lack of capacity to love others. Thus, internal as well as external conditions can contribute to the crisis that precipitates suicide. Not only frustration, hostility, and aggression may be central, but feelings of guilt, anxiety, dependency, helplessness, hopelessness and abandonment also may exist.

Often considered an act of communication, suicide aims to force a change. The suicidal person's situation is such that he or she no longer wishes to continue living in it.⁹ Such a person, however, is not necessarily completely intent upon committing suicide. For most suicides, the goal is not death, but the eradication of some problem. Suicide seems a means of accomplishing that goal.

From the psychological model, we have come to recognize the following: 1) that the acute suicidal crisis is usually of brief duration, but it may recur; 2) the suicidal person is likely to be ambivalent about ending his or her life; there are usually fantasies about being rescued, and/or that last minute intervention will occur before the act is completed; and 3) that most suicidal events are dyadic, i.e., they usually involve the victim of a suicide and a significant other in some way.

One should not view these two perspectives as antithetical. On the contrary, almost all suicidal acts involve elements of both. All individuals are connected, for better or worse, to the families and societies into which they are born. In turn, families and the social context will have affected the individual's personality development, and learned ways of coping with stress and anxiety.

Because so many variables are involved, suicidologists are still not able to provide a single "psychological profile," or list of person-environment characteristics that can enable one to identify readily and consistently a suicidal individual. There are clues and signs that communicate that an individual may be considering suicide as a "way of coping," and one of the key signs appears to be depression. It is now recognized that children of elementary school age, as well as adolescents, can suffer severe depression, but that it may be manifested differently in the behavior of these two age groups. The ways in which it can be manifested will be described in a later chapter.

A Different Kind of Death

It needs to be recognized that suicide is viewed almost universally as a "different" kind of death. Death generally, as we have come to know, is a taboo topic in our society, and death denial is abundantly evident. But deaths due to illness, accidents, old age, disasters, wars, etc. tend to be separated in our feelings from suicidal deaths. Death by suicide seems not only "irrational," but tends to have a shattering effect on all those it touches.

Why is suicide so shattering? What seems to distinguish suicidal death is that it is interpreted as an act of communication. At the same time, it is a communication to which one cannot respond appropriately or meaningfully because the dialogue has been cut off. Family members, in particular, can feel stigmatized, can feel that they have failed, and that they are being held responsible in some way for the act without being able to prove otherwise. Yet, there is hardly ever a simple cause-effect relationship linking significant family members, and/or peers to the suicidal act.

This single act of terminating one's own life can engender in families and in social groups (such as schools, neighborhoods, clubs, etc.) with which the suicidal individual was involved pervasive feelings of guilt, frustration, and remorse. In time, angry feelings may surface as well. Inevitably, a self-examination process occurs, both consciously and unconsciously, and this can make people uneasy, uncomfortable and upset.

There is also frequent concern that an adolescent suicide that may be dramatically publicized will have a "contagious" effect. This may lead to an emphasis on "hushing it up," to almost deny that it has occurred. Such dismissal may actually be more harmful, as it can "romanticize" and "glamorize" the act because it will be discussed in secretive ways, in innuendos. In point of fact, there is no real evidence that suicide is spread in an "infectious" way. Rather, if additional suicides occur, one should recognize that the individuals involved had to have been seriously at risk prior to the suicide and were not recognized as such.

Myths and Facts

Everyday more than 1,000 young people in the United States attempt suicide - and this is only the reported figure. Many experts believe that suicide is, in fact, the number one cause of teenage death in this country. Tragically, it is also the nation's number one preventable cause of death. Suicide is a cry for help that backfires -- a cry for help that demands intervention.

All too often the adolescent's cry for help is not heard because of our own fear, superstition and the built-up mythology that has surrounded suicide for centuries. Books of mythology are generally taken as light reading, but believed myths surrounding suicide can literally be the difference between life and death. Most often when myths are exploded, the veil of ignorance is lifted, and denial is lessened. Listed below are some of the most common fallacies about suicide as well as the factual responses based upon the most modern research.

1. Myth: People who talk about killing themselves rarely commit suicide.

Fact: Most people who commit suicide have given some clue or warning of their intent; therefore, suicidal threats and attempts should always be treated seriously. Also, of any 10 persons who kill themselves, eight have given definite warnings of their suicidal intentions.

2. Myth: If you ask a person about his suicidal intentions, you will encourage the person to kill himself.

Fact: The opposite is true. Asking directly about suicidal intent will often lower the anxiety level and can act as a deterrent to suicidal behavior by encouraging the ventilation of pent-up emotions. A note of caution is also important: one should never pontificate about how much the individual has to live for, or how terrific he/she is, etc. The suicidal person has heard it all before and probably will not believe it. By attempting to make the individual "feel good" due to your anxiety and denial, matters can become much worse. It is far better to listen actively.

3. Myth: Suicide happens without warning; it is a spontaneous activity.

Fact: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions. In fact, most suicidal people plan their self-destruction in advance and then present clues indicating that they have become suicidal. A case in point is the following poem written by a 15 year old boy, two years before he committed suicide:

TO SANTA CLAUS AND LITTLE SISTERS

Once...he wrote a poem
And called it "Chops."
Because that was the name of his dog, and that's what
it was all about.
And the teacher gave him an "A"
And a gold star
And his mother hung it on the kitchen door, and read
it to all his aunts...
Once...he wrote another poem
And he called it "Question Marked Innocence."
Because that was the name of his grief and that's
what it was all about.
And the professor gave him an "A"
And a strange and steady look.
And his mother never hung it on the kitchen door,
because he never let her see it...
Once, at 3 a.m.....he tried another poem...
And he called it absolutely nothing, because that's
what it was all about.
And he gave himself an "A"
And a slash on each damp wrist
And hung it on the bathroom door because he couldn't
reach the kitchen.

Other signs might include: giving away prized possessions; depression (or extended apathy); loss of appetite or increased eating; change in sleeping patterns; change of personality; verbalization ("What's the use, you won't be needing or seeing me around anymore."); change of lifestyle; increased drinking or drug abuse; withdrawal; etc.

4. Myth: Suicidal people are fully intent on dying and feel that there is no turning back.

Fact: Most suicidal people are undecided about living or dying. They are generally ambivalent and may gamble with death, leaving it to others to rescue them. Almost no one commits suicide without letting others know how he is feeling. In fact, many people will call for help immediately following an attempted suicide.

5. Myth: All suicidal people are deeply depressed.
- Fact: It is a fact that in 75 to 80% of all suicides, depression is a contributing factor. However, some suicidal people appear happier than they have been in quite a while because they have decided to "resolve" all their problems with a single act.
6. Myth: Improvement following a suicidal crisis means that the suicidal risk is over.
- Fact: A very important time to be extra vigilant is when a depression is seemingly lifted and the individual appears to be at risk no longer. Many suicides occur within about three months following the beginning of improvement, when the individual has the energy to put his morbid thoughts and feelings into action.
7. Myth: Once a person is suicidal, he/she is suicidal forever.
- Fact: Most people who are suicidal are that way for only a brief period in their lives. If attempters receive the proper assistance and support, they probably will never be suicidal again. Only about 10 percent of attempters later complete the act.
8. Myth: Suicide is basically a problem that is limited to people who are relatively young.
- Fact: Suicide rates rise with age and reach their peak among the elderly.
9. Myth: There is a very low correlation between alcoholism and suicide.
- Fact: Alcoholism and suicide often go hand in hand. Alcoholics are prone to suicide and even people who do not normally drink will often ingest alcohol shortly before killing themselves. What makes alcohol dangerous in the adolescent is that not only does it increase depressive feelings, but can have the effect of increasing impulsiveness and utilization of very poor judgment. Developmentally, in adolescence one has remnants of magical thinking about his or her omnipotence and understanding of what death is. If one couples this developmental phenomenon with alcohol use, the combination can indeed be lethal.
10. Myth: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
- Fact: Studies of hundreds of genuine suicide notes indicate that, although the suicidal individuals tend to be extremely unhappy they are not necessarily mentally ill. This statement, of course, does not apply to the truly psychotic or substance-induced psychotic.

11. Myth: Suicide strikes much more among the rich or, conversely, it occurs exclusively among the poor.
- Fact: Suicide crosses all socioeconomic groups and no one class is more susceptible to it than another. The causes of suicide are many and varied including economic, political, sociological, psychological and cultural factors in any and many combinations.
12. Myth: The tendency toward suicide is inherited and passed from generation to generation.
- Fact: Suicide is not transmitted genetically, although it does tend to "run in families." What is also possible is that a young child in the development of his or her sense of identity may have a parent who is chronically depressed, or may have committed suicide, thereby setting the stage for self-destructive behavior in adolescence. This is caused, in great part, by identification with the suicidal parent or sibling and viewing suicide as the way out of problems. Additionally, if very young children are abandoned with no caretaker or significant other in their lives they, too, are at risk.
13. Myth: Suicidal people rarely seek medical attention.
- Fact: Research has consistently shown that about 75% of suicidal people will visit a physician about three months before they kill themselves. This fact, however, speaks to the inability of many professionals to recognize the signs of depression and to understand their own defense mechanism of denial.
14. Myth: Professional people don't kill themselves.
- Fact: Physicians, lawyers, dentists, and pharmacists appear to have high suicide rates.
15. Myth: Because it includes the Christmas season, December has a high suicide rate.
- Fact: There is not a rash of suicides at Christmas and December has the lowest suicide rate of any month. What seems to happen is that during the Christmas season, the depressed person feels some sort of belonging, through the extension of cheer via strangers. They feel things may get better. However, as spring comes and their depression does not lift by seeing rebirth and newness and freshness about them, they may become more depressed and become overtly self-destructive. Actually, April is the month with very high rates of suicide.

These myths are some of the more significant that have been pervasive among the beliefs regarding suicide.¹⁰

PUBERTY, ADOLESCENCE AND ITS CRISES

"When I was seven, my father knew everything, when I was fourteen my father knew nothing, but when I was twenty-one, I was amazed how much the old man had learned in those seven years." This quotation by Mark Twain highlights the dilemma of adolescence. Originally, an adolescent's world is determined to a great extent by the stability of the relationship to the parents. In adolescence, the world becomes less defined and it is one of the tasks of adolescence to redefine one's world in his or her own way by exploring, experimenting, and exposing oneself to new experiences and situations. In this search, the young person may discover that the world is sometimes thrilling and exciting; sometimes depressing and frightening.

Adolescents face a tough time growing up and adjusting to the biological changes of puberty, to increasing peer pressures, to environmental overstimulation (the notion that they have to look like that model in the ad for jeans). In addition, adolescents face the pressures of moral and religious considerations. All of this can be occurring at the same time that the adolescent is coping with separation and loss -- separation from parents and the nuclear family, and the loss of childhood. What looms ahead is entry to the adult world. This is pursued, however, with a great deal of ambivalence. It is not accidental that when adults review their own development the one stage they are not likely to want to recall (or to re-experience) is typically the stage of adolescence.

It is generally acknowledged that the period of adolescence is a time of turmoil and excitement. Adolescents also confront many pressures and stresses -- from home, school, and the community. Teenagers are expected to be good students, at least adequate athletes, to have friends and be popular. At the same time they are expected to have acceptable morals and values.

Adolescents tend to walk a very fine line between the desire to be different, with a unique pattern of dress, style and behavior; and the great need to be exactly like everyone else in the group. In the process of separating from their families, adolescents find themselves even more thoroughly dependent on their peer group. Adolescence is a time when too much dependency on parents is considered immature, but individual autonomy has not yet sufficiently developed. The peer group, however, does not necessarily provide social, emotional and psychological support. Consequently, the parallel feelings of a need for conformity with peers, and negativism towards parents and adults seems to increase during early adolescence, and can reach a peak between the ages of 14 to 16. It is also important to realize that such feelings can last for a longer time.

The need of adolescents to become independent is so basic that the young person is pushed to develop new views, values and forms of behavior. In the process, adolescents appear to abandon that part of the self that reflects the original identifications with their parents. However, in stripping parents of their virtues and powers, in questioning their values, the adolescent is also divesting him/herself of parental security and support. Thus, adolescents in the midst of peers and various external group experiences may well be contending with feelings of loneliness, isolation, and depression. Their need for support and guidance becomes vital.

It has been pointed out that during adolescence, the teenager is experiencing the beginning of sexual maturity and many biological changes simultaneously. These changes can create fear, anticipation and confusion in the young person. The initiation of puberty and the radical changes in the adolescent's bodily appearance and related self-image takes getting used to. The typical teenager worries greatly about physical appearance. When a young adolescent male looks into a mirror and notices that his nose is too large, or his ears stick out, his anxiety about his "grotesqueness" is not always alleviated by his parents or teachers. Assuring him that his face will catch up with his nose and ears because they grow more quickly than the other parts of his head frequently is ineffectual. Often, we don't take the time to explain to adolescents that their clumsiness is due to their rapidly growing bodies. Instead, they are often criticized for their awkwardness.

The powerful physiological and psychological changes that take place during adolescence are further complicated by the teens' need to consolidate their developing understanding of death as an irreversible event, and, consequently, their own loss of fantasied immortality. Thus, thrill-seeking behavior of various kinds may occur, and seem to be aimed at "testing the limits," through gambling with death. Not dying tends to confirm for them their invulnerability and uniqueness. This notion can be evident in the suicidal ideation of young people that they will not really die. It is not surprising, then, that drug abuse, acting-out behavior, depressive episodes and suicidal attempts occur during this period of development. For many young people, the choice is drugs and/or anti-social behavior for instant gratification. If there is a pervasive dread of adulthood, of shifting from childhood dependency to independence, drugs and alcohol in particular can help to dull ambivalence and frustration and facilitate the manipulation of behavior.

Unfortunately, social pressures upon adolescents appear to be increasing rather than decreasing. The value of education is questioned, especially when fewer jobs for graduates seem to be available. The continual specter of the danger of nuclear warfare; of power plants emitting radioactivity; of environmental pollution which can harm adolescents and their offspring arises. With all this, there are increased demands to produce, to be able to meet any and all competition which can leave many young people with a pervasive sense of not being able to measure up.

It is not uncommon to find in the suicide notes left by adolescents references to deep feelings of social ineptitude. The teenager may begin to feel isolated, alone, possibly rejected, and that there seems to be no way to "turn things around." Feeling hopeless and helpless can engender a kind of "tunnel vision," in which various experiences tend to confirm for the isolated adolescent that there may be no other option but suicide to end the intolerable emotional pain involved in living with such an exceedingly poor self-image.

For minority adolescents, there is an additional crisis, the poor economic present and future many of these youths face. Unemployment in this group remains staggeringly high. In addition, the decades of the '60s and '70s with their civil rights advances have raised expectations, especially among young people. The current decade seems to be dashing

these hopes, and if this continues, can lead to the despair that induces chronic depression. It needs to be emphasized that for the minority adolescent this tends to be an additional stress, on top of the developmental stresses confronting all adolescents.

In our culture, we tend to approve of children, but derogate adolescents; to belittle their appropriate fears and concerns. Adolescents need, as we all do, people to listen to them; to respect them; to nurture them; and, most of all, to be able to communicate with them. They also need the recognition that they are on the verge of adulthood, and that this is by no means an easy transition.

By becoming more aware of the "adolescent" within ourselves, perhaps it can help us acknowledge that teenagers are much more like us than the strangers they are often made out to be.

EARLY IDENTIFICATION

Any discussion about early identification of pupils who may be at high risk for suicidal behavior must take into account the strong possibility of underlying depression.

Adolescents are prone to have a fragile coping system that is rife with the belief that no one understands them, and that their problems are unique. When external pressures begin to overwhelm, many teenagers find it difficult to ask for help because the entire thrust of development at this stage is geared toward independence. If no one hears a teenager's muted cries for help, he or she may react with extremes of problematic behavior such as truancy, drinking, rebellion, substance abuse, running away, and/or suicide. These reactions are not usually psychotic.

As stresses seem to increase and suicide is contemplated, an adolescent may try to communicate his/her feelings to friends, parents or teachers. The teenager may even want to see a doctor in the hope that the need for help will be discovered. When this fails (and it often does) any crisis in which the adolescent ego is injured, may precipitate the final decision to attempt suicide.

Although almost all students can experience transient depressive feelings, some students may be at greater risk for more serious depressive episodes. For example, students who have been referred to the child study team, students who are known to be using drugs and/or abusing alcohol, students in families where there are parental and/or familial problems, students with diagnosed developmental disabilities, students experiencing educational difficulties, and students who appear to be unusually accident prone all have a greater tendency to be at risk. Feeling depressed in the situations that these students may be encountering may be quite appropriate. One should not immediately assume that such students are suicidal. Rather, one needs to be sensitive to additional clues or signs which may indicate that some of these students are indeed considering solutions to their problems which are essentially self-destructive, because of the underlying depression.

Edwin Shneidman and Norman L. Farberow have grouped signs, or clues, of suicide into four broad areas which can be helpful in early identification of high risk students: Verbal, Behavioral, Situational, Syndromatic.¹¹

I. Verbal Clues

- A. Direct statements "I wish I were dead"; One should not be misled by statements like, "I didn't mean to say it!" or "I only wanted the attention" - statements like these need to be further explored to be sure of the actual intent.
- B. Talk of death or the hereafter, e.g., what it would be like to be dead, or of wanting to join a beloved person who has died etc.

II. Behavioral Clues

- A. Any previous self-destructive attempts;

- B. Making a will; giving away prized possessions; going about setting one's affairs in order.

III. Situational Clues

- A. Depressed talk of family strife, possible divorce, separation of parents, illness, or financial problems in the family; any knowledge of family history of suicide and depression within the family.
- B. Loss of job, friends, family members, or significant adult/peer relationships; change of address; divorce/separation in family; school failure; loss of status in school, in athletics or school clubs; loss of pets. Any of these situations may trigger serious depressive episodes.

IV. Syndromatic Clues

- A. Depression (the most prevalent syndrome). Adolescents of 16 or 17 years of age may present symptoms of depression similar to those found in adults, i.e., dysphoria, lethargy or agitation, sleeplessness, or too much sleep. There may also be difficulty in expressing one's thoughts (hesitant speech, flattened affect, or a masking of their depression via somatic complaints).

In younger adolescents and children of latency age the classic profile of gloom and depression is usually missing. The more common signs may be: boredom, restlessness, hyperactivity which may be at times mistaken for a neurologically based disorder, constant fatigue and increased preoccupation with the body. Difficulty in concentration may also occur.

A note of caution: The teenager or pre-adolescent who exhibits some combination of the above symptoms should be referred, via his/her parents, to a physician in order to rule out any organicity or neurological involvement.

- B. Disorientation. If teenagers and/or pre-adolescents should mention hearing voices, or people telling them to destroy themselves, or others, parents should be immediately contacted, and/or referral made to appropriate child study team resources.
- C. Defiance. There are individuals who insist on controlling their own destinies - including their own deaths. These are students who always need to be in control and who, therefore, will take chances with their own lives through suicide.
- D. Dependence - Dissatisfaction. Students who perceive themselves as trapped in a hopeless condition, i.e., they have experienced a significant loss, and see no way out of their dilemma, and may choose to attempt suicide as a solution.

Other possible danger signs are also encompassed within Shneidman's areas. These signs, however, need to be viewed within the context of the student's overall situation. These include possibly self-destructive behavior such as carelessness and accident proneness in younger children, and numerous accidents in the older adolescent.

Loss of appetite or excessive eating, i.e., an abrupt change in a child's eating habits is frequently an early sign of trouble. Some teens -- almost always girls -- can manifest serious eating disorders. Typical are anorexia-nervosa and bulimia. Like alcoholics or drug addicts, these children may be "killing themselves slowly." As well, a decrease in verbal communication, withdrawal from peer activities and from previously enjoyed activities, or excessive latenesses, sleeping in class due to students' indicating frequent lack of sleep, sudden academic decline, or erratic school performance in various areas should not be ignored.

Following a loss, (as reviewed under "situational clues") either too quick a recovery, which may be an indication of trying to hide depressed feelings, or unusually despondent behavior (excessive tearfulness, apathy, loss of appetite, withdrawal from activities, etc.) warrant exploration. [Feelings of helplessness, worthlessness, and hopelessness may be evident, and if not transient, and if found in association with the loss of relationships with significant others, may trigger suicidal behavior.]

One also may see reduced frustration tolerance, hostile behavior as in fights, serious altercations with peers, unruly behavior in school and in the home or community. Almost any sustained deviation from the adolescent's typical pattern of behavior should be taken seriously and evaluated further. Further, sudden, inexplicable euphoria, or whirlwind activity after a spell of gloom could mean that a student has decided to gamble with suicide.

Since suicidal behavior always involves multiple factors, no one behavior should be viewed in isolation. It is the clustering of these behaviors that is more likely to be significant. In order to determine how much a student may be at risk, if one or more of the above behaviors should be evident, the most important response is to explore with, engage and listen to the student. Students, most of all, need to be "heard" by school personnel.

In summary, the sequence of events that seems to lead an adolescent to attempt suicide appears to be the following:

- o a long history of problems not of the adolescent's own making;
- o a period when the problems escalate;
- o failure of the adolescent's adaptive techniques for coping with the problems and the attendant development of feelings of despair;
- o new problems which take on crisis overtones and lead to progressive isolation from meaningful relationships; and
- o the final phase of isolation shortly before the adolescent decides that death "...is the only way out."

FAMILY CONSIDERATIONS

The family provides the basic unit for child rearing in our society. It is within the family unit that children develop physically and psychologically. However, in today's society, families face ever-increasing challenges. Rapid social changes created in part by technological advances increase the stress placed on the family unit. This, as well as the proliferation of single parent families, has complicated the child-rearing task.

Other pervasive but insidious forces which often influence youngsters are the media. Families are competing with million dollar advertising promotion budgets that many times endorse life styles in direct opposition to the family value system. Recorded music is also of potentially negative influence. For example, suicidologists cite the Elton John song, "Think I'm Gonna Kill Myself" which ends with the words, "I'd like to see what the papers say on the state of teenage blues" as an illustration of this potential influence. Songs such as this are particularly harmful because they impact on the lives of those in adolescence -- a period of maximum vulnerability. Thus, families of today confront formidable odds in raising happy, healthy and productive members of society.

The suicidal adolescent, as an integral part of the family "system," may be communicating despair with self-destructive behavior. This behavior may also be a signal that the family unit is in distress. There has not been sufficient research data to indicate the "types" of families that have a high risk of a suicidal adolescent. Completed suicides have occurred in all types of families cutting across social and economic barriers. It is thought that factors which influence the suicidal person are numerous and include biological, psychological, familial, and societal circumstances.

Upon recognition of suicidal behavior in a youngster, it is the duty of the designated school personnel to notify the family. Although families may be shocked and surprised by this information, they will usually follow through on the school's recommendations for intervention. This most likely will include referral to an appropriate therapeutic setting for an assessment of the severity of the problem. The treatment plan may include individual, family and/or group therapy in an outpatient setting. In cases of youngsters with a high risk for suicide, hospitalization may be necessary. Quite often, families may have been experiencing stress with the youngster at home and may welcome guidance from school personnel.

Conversely, school personnel may contact the family and be met with hostility, denial and resistance to seeking therapeutic help. It is important for a school system's personnel to recognize families who will not be able to respond appropriately when a member is at risk of suicide. They may make the logical assumption that the family is a prime resource when dealing with suicidal youngsters. In these situations, expecting the family to be a resource is a little like trying to draw water from a depleted reservoir. Chances are that one will come up dry in both situations.

Two major categories of familial situations which may affect the family's ability to respond appropriately to the suicidal crisis of a youngster are those families who have experienced recent stressful life events and

families with chronic stress. In the first category, significant life stress events may have placed such a burden on the family that their routine coping mechanisms are enervated. Any changes in financial, vocational, living situation; physical health; the addition of new family member(s) or loss of a family member through death, divorce or separation tends to make the family more vulnerable in future crises. It has been observed that families who have experienced many stressful situations had greater difficulty with additional crises. Once defeated by a crisis, these families appear not to be able to marshal forces sufficiently to face the next event. Families in these situations may experience continuous, cumulative defeat.

The second category includes families with chronic stress, such as mental illness of a parent (e.g. schizophrenia, depression), patterns of parental drug and alcohol abuse, chronic marital discord, and immature parents who are not up to the task of parenting. Also at risk are families that are too rigid, too authoritarian or too laissez-faire. These families usually do not provide the proper environment necessary for the developmental stage of adolescence.

In the ideal situation, the school and the family will work jointly in the interest of the child. If this is not feasible and all means to engage the family are unsuccessful, other resources must be explored. This may include a referral to a child protective agency because failure to obtain services for a suicidal child is considered child neglect. Through all of this, it cannot be stressed enough that the school personnel are the vital link between the family and the therapeutic agency.

COMMUNITY RESOURCES

It has been found to be of real help to young people, their families, and other adults if a community's social and emergency resources are identified and widely publicized. The resources in a school system's catchment area need to be identified and their availability for crisis intervention and follow-up services thoroughly explored. Listed below are the kinds of resources that can be of help to suicidal adolescents, to their families and to school personnel.

Resources

I. Emergency

- o police
- o ambulance, first aid squads
- o fire department
- o location of hospital emergency rooms
- o hot lines, (re: suicide, drug use, for runaways, child abuse, Contact, etc.)
- o drug abuse centers, or programs
- o alcoholics anonymous
- o clergy of various denominations
- o battered women programs
- o juvenile justice programs

II. Community Outpatient Agencies

- o mental health centers, non-sectarian and sectarian
- o medical outpatient services for adolescents
- o drug, substance abuse programs (rehabilitation and educational)
- o family service agencies, non-sectarian and sectarian
- o crisis intervention programs
- o information and referral centers (community or county-wide)
- o pregnancy counseling services
- o venereal disease information and treatment
- o youth-serving agencies, such as Y's, community centers, etc.
- o any adolescent outreach program in the community/county, (public or private, sectarian or nonsectarian)

III. Community In-patient Agencies

- o adolescent units within general hospitals
- o adolescent units within psychiatric hospitals
- o halfway houses for adolescents
- o group homes for juveniles

IV. State Agencies

- o New Jersey Division of Youth and Family Services - local offices
- o New Jersey Division of Mental Retardation - local offices
- o New Jersey Division of Vocational Rehabilitation - local offices

V. Other Resources

- o local health boards
- o Society of Compassionate Friends - local chapters
- o self-help groups for survivors of suicide

Small communities and certain counties in New Jersey may not have the range of resources identified above. It is recommended that school systems within such communities explore the possibility of linking up with neighboring communities, where specifically needed resources may be available, and establish reciprocal resource use agreements. The critical factor is making help readily available when it is needed and avoiding the duplication of costly resources.

This listing is extensive (although not exhaustive) in order to alert communities to the possible range of resources that can be tapped, and may be of help to those facing a suicidal crisis. It is strongly suggested that a wallet-sized card listing the most important community resources that will respond most readily to an emergency involving an adolescent at risk for suicide be produced by school systems and widely distributed within their communities.

INTERVENTION AND FOLLOW-UP

It would seem common sense that knowledge on the part of a school staff member of a young person's intent to engage in a suicidal act would require some attempt at intervention on the part of the staff member. Fortunately, in this situation, common sense and case law would seem to coincide. Under no conditions should information of this kind be kept strictly confidential by the staff member who receives it.

While the concept of confidentiality remains an issue for educators in general, and psychologists and counselors in particular, it is clear that legislation in this regard is designed for the protection of the client, not the professional. Even under legislation granting privileged information there are certain exceptions, most notably in cases where the information pertains to future criminal or dangerous activity. There is strong suggestion that a teacher, nurse, counselor, psychologist, etc. may not keep information confidential if there is the potential of imminent danger at hand; indeed he or she can be held liable if the information is not given to the appropriate person.

It is obviously desirable from the point of view of encouraging effective intervention that staff, both professional and auxiliary, be aware of the need to act on information regarding threatened or suspected suicidal acts. Local school board policy in this regard is a recommended first step. Such policy might be adopted under "teacher roles and responsibilities" or other appropriate policy areas. Such policy, if not already in place, should be recommended to the board of education. In addition to policy which clearly and forcefully requires staff to act upon suicide-related information, specific building level procedures for carrying out the policy need to be developed and effectively communicated.

From a very practical point of view, it is important to have a clearly understood set of procedures for reacting to suicidal acts; either as they are attempted, threatened or discussed after the fact. Three steps are vital:

1. Ensuring the short-term physical safety of the student;
2. Communicating with appropriate school personnel, parents or guardian and local support personnel and establishing an interim plan of action; and
3. Referring to appropriate professional or agency and implementing a long-term plan of action.

Each of the steps needs further examination.

1. Ensuring the short-term physical safety of the student would include:
 - a. securing immediate medical treatment where suicidal attempt has occurred;
 - b. securing police and/or other emergency assistance where a suicidal act is being actively threatened;

- c. keeping a student under continuous adult supervision when a suicidal act is less actively threatened, but is a serious possibility; and
 - d. monitoring students' actions where an unsuccessful suicidal act has been reported, or threatened.
- 2. Communicating with appropriate school personnel, parents or guardian and local support personnel and the establishing of an interim plan of action would include:
 - a. notification of one or more of the following: counselor, school psychologist, nurse, principal or other building administrator, and the central office administration;
 - b. contact by designated school professional with parent or guardian (while seemingly common sense, this step must not be overlooked nor become the subject of bargaining between staff member and student);
 - c. contact by designated school professional of other local support personnel, including local police, counseling agencies or private therapists (this may not be required immediately in all cases); and
 - d. the determination of an interim plan of action through which the school can transfer responsibility for the student's welfare to the parent and/or the appropriate support agent or agency.
- 3. Referral to appropriate agent or agency and implementation of long-term plan of action would include:
 - a. follow-up of interim plan;
 - b. strong recommendation that parent contact one or more of the local helping agencies; and
 - c. timely follow-up on the part of designated school professional regarding parent and student contact with local agent or agency.

The intent in all of the above is to emphasize the school's role as being sensitive to "at risk" students and/or steering such students and families toward appropriate family treatment resources. For each situation, staff members need to be fully aware of how to get help immediately. The school can also help in urging continued treatment and conducting appropriate follow-up.

Impact on School Personnel

It is important to emphasize that suicidal threats, gestures or reports be treated seriously. While there are obviously degrees of seriousness, no situation should be treated casually. Students need to know that

suicidal acts will be treated quickly and seriously and the school will react in each and every case. For the protection of the student involved and the rest of the student body, a student who has attempted a suicidal act may be temporarily removed from school. It should also be pointed out that while suicidal acts may result in temporary removal, since they obviously "constitute a continuing danger," that such temporary absence is used only as a means of ensuring that proper treatment is begun rather than being a punitive measure. Treatment of suicidal acts simply as a disciplinary problem is inadequate and inappropriate. While this is obvious in many cases, occasional suicidal situations such as drug or alcohol overdose may not be fully clear. Long term student mental health is the primary focus.

It is essential in a school to establish and encourage an atmosphere of supportive interaction. In the area of suicide, this requires that the staff be adequately trained, not only in understanding the myths and realities of suicide and recognizing the signals, but in strategies of intervention. In the high school setting it is frequently the guidance counselor who becomes the intervening party. Teachers, however, are likely to be the first to recognize signals.

Initially, it is important to conduct in-service sessions for teaching staff aimed at recognizing signals and understanding causes of suicide. This should be a regular in-service program, not one that is hurriedly offered following an actual or attempted suicide. Such an in-service program would also emphasize the need for teachers to transfer problems to support personnel, though it may be appropriate for teachers to become involved occasionally in direct intervention.

Training Considerations

Counselors, school social workers and school psychologists need specific training in how to intervene with suicidal students. They need to know how to examine with the student exactly what happened in a previous suicide attempt. Further, they need to know how to introduce an alleged suicide note into conversation with the student and how to introduce third party information. While the need to deal openly with the problem or the threat of suicide may seem obvious, it is an awkward and difficult topic with which to deal honestly and directly.

Support personnel also need to be trained in intervention strategies with parents. Introduction of the topic with parents can bring reactions which range from outright panic to denial and anger. A calm, measured approach, which encourages involvement, recognition of a serious problem and acceptance of the need for professional help is the desired strategy. It is essential that this kind of approach be developed. Appropriate role playing exercises can aid in such development. Since adolescent suicide is an area in which the practicing professionals need to be fully aware of their own feelings, it is important that in-service work be addressed in part to an examination of one's own values and feelings relative to suicide.

The evidence suggests that suicide occurs more frequently among educationally handicapped youngsters than in the general population. Since this is so, it is particularly important that members of child study

teams become knowledgeable about suicide and skilled in intervention strategies. The school psychologist, social worker, learning specialist and nurse should be recognized in the school as knowledgeable in the area of suicide prevention. It can be particularly beneficial for a school to have a school nurse who is able to recognize physical and emotional clues that point toward a suicidal attempt or constitute other self-destructive behavior.

Equally important is the need for a school system to recognize that suicide attempts on the part of young people sometimes will be, in spite of all efforts to the contrary, successful. Schools should have a well thought out and clear strategy for dealing with suicide after the fact.

Returning to School

A thorough review of the literature, research and curriculum guides on adolescent suicide has failed to produce any suggested procedures, or guidelines concerned with the student who returns to school after a suicidal gesture, or a suicide attempt has been identified. Speculation is that teachers, administrators and parents might not want to deal with the student due to the nature of the problem. Suicidal behavior is still stigmatizing and there is a tendency to ignore it. This tendency may be the result of compassion, feelings of helplessness, embarrassment, fear of the student being labelled, and/or denial. Whatever the reason, there is much concern that little follow-up takes place, and that all goes back to "business as usual."

Therefore, some suggestions have been developed that may be helpful in the event one is faced with the adolescent who has just returned from a hospital stay, or if one has learned informally that the student's absence was related to a suicidal gesture or attempt.

- Generally, a member of the school's guidance or special services staff should be apprized of the situation by an administrator or teacher who is privy to such information.
- The student's teachers can be informed of the student's absence with a short statement as follows "Johnny D. has been hospitalized and will be returning to your class shortly." In addition, selected teaching staff may be informed, in confidence, with the understanding that they will respect confidence as to the actual nature of the absence.
- The returning student should not be treated any differently than any other student who has been absent due to illness. Suicidologists have stressed that, as much as possible, a student should be returned to his/her normal routine within the school.
- Contact with parents and the student should be made, if possible, by guidance and or special services staff, and with the treating therapist, if one is involved, to discuss ways of helping the student to cope more effectively with school related stress.

- Teachers and other school personnel should be encouraged to discuss their concerns, no matter how minimal, with appropriate staff. It is very understandable that teachers, nurses and other school staff may have concerns about how they should respond. There needs to be resource people within the school systems with whom staff can confer on an ongoing basis. Collegial support is imperative and indispensable.
- Periodic, discrete checks should be made by guidance and special services staff with the student's teachers, and other appropriate school staff such as nurses, coaches, etc. Also, attendance records, dean's office records and, academic standing reports should be reviewed periodically in order to assess and evaluate the students's overall adjustment.
- Contact with the student's parents must be maintained in order to extend support, encourage parental involvement and to report progress.

All of the above should be undertaken in as "matter of fact" manner as possible so as not to create undue anxiety. This means that key personnel who are trained to deal with suicidal phenomena, need to convey to the students, parents, and school staff that this situation can be handled, is manageable and that there is no need for panic. Thus, attention must be paid to communication within the system, and that, as much as is feasible, there should be open communication among all concerned.

Certainly, an issue as important and sensitive as a suicide attempt is that of a completed suicide. First, suicide must be recognized as the act of a distraught person; it is not and should not be viewed as a noble alternative.

It may even be construed as "murder" directed at oneself, in order to cope with extreme feelings of helplessness, hopelessness and worthlessness. Any recognition which tends to glamorize or romanticize the act or the victim should be avoided. While this may cast the school administrator in a less than sensitive mold, it is the living who should become the chief concern of the school. Where subtle messages can be sent out that the suicide victim is not to be admired and the act not to be respected, it is a desirable attitude to foster.

Second, it is important to realize that students and staff may need the opportunity to deal with their own feelings regarding suicide as well as more traditional feelings of grief. The availability of support personnel to meet these needs has to be recognized. Throughout the school day following a suicide, students should be allowed to leave class and see support personnel on an as-needed basis. Whatever process of grieving takes place, it is important that it be isolated and kept under control. Any large group meeting, an assembly for example, should be avoided. Emphasis during the day should be on creating opportunities for individual or small group communication between students and support personnel.

In addition, the school system has to provide for such necessities as contact with newspapers and other media services. There should be one person designated to handle such matters. Notification of staff, and system-wide administrators, etc., should be carried out in a planned, calm manner. The school must be prepared to react to visitors, particularly those from the media, in a respectful, yet forceful manner. Above all, care must be exercised to maintain the focus of the school as an educational center.

The "contagion" factor in a school must be taken into account. Since there is evidence that students who are already "at risk" will respond more emotionally to crises than those who are more mentally healthy, it is important that such students be identified and contacted. While this contact should be informal and as matter-of-fact as possible, it needs to take place. Support personnel should review the cases on which they have spent significant time, designate those who might be "at risk" and arrange to be in contact with these students. Appropriate intervention steps should be taken with students who are thought to be in serious difficulty. Where plans are made for this aspect of reacting to suicide, this effort can be accomplished with little notice and in a reasonably normal fashion.

Following a suicide, those involved in helping a school deal with the crisis should themselves go through a "debriefing;" an exercise in which not only appropriate self-examination is engaged, but where those involved have a chance to deal with their own emotions and can communicate openly on a continuing basis. This can be a time for re-examining and re-vitalizing links with the community, social agencies and parent groups.

Until there is a dramatic reversal of national and international trends, teenage suicide will remain a problem. Few schools which house adolescents will escape dealing with the problem entirely. For most, it will be a matter of when and how often. It behooves administrators, therefore, not only to plan the manner in which a school reacts, but to develop in staff and community an awareness of the problem and a realization that they are not to blame. In order to deal effectively with the student body as a whole, school staffs must view suicide as a phenomenon that can be dealt with; not a process to which they have contributed.

Underlying all is the necessity for planning. Though it may seem almost macabre, suicide and certain other severe crisis situations must be planned for in much the same way as snowdays, fires and more traditional, less personal problems. Planning does not encourage the event; it allows the school to react in a manner that serves all students and staff well.

Profile of A Trainer

Generally, trainers need to be people who have begun to confront issues of death and dying for themselves, and who are able to face the nature of suicidal death. There also needs to be an ongoing commitment to intervention with and prevention of suicidal acts in youth. To function as a sensitive trainer, one needs not only initial training, but also a readiness to reevaluate and update one's training and skills.

Specifically, the following attributes in a trainer are highly desirable:

1. Ability to create a non-threatening environment when teaching and/or training;
2. Ability to elicit concerns that others may be feeling, and to listen to others non-judgmentally, to respond appropriately and to be sensitive to other's needs, pressures and attitudes;
3. Have some understanding of group interaction and dynamics;
4. Ability to teach a group of people, organize, interpret and communicate the information contained in the Adolescent Suicide Awareness Training manual;
5. Ability to communicate effectively complex ideas and conceptual issues;
6. Ability to communicate in a direct, organized manner;
7. Given the nature of the topic/problem being addressed, trainers need to have considerable self-awareness regarding the ways in which anxiety and/or stress can manifest itself within themselves, in interaction with the targeted group to be educated and/or trained; and
8. The trainer should possess values such as: respect for individual worth, confidence in behavior change potential, compliance with codes of professional ethics, respect for other professionals, and respect for individual differences.

SUMMARY

A consistent theme which emerges when one focuses on suicidal death, as in the preparation of this training manual, is that death by suicide is "different" and frequently devastating for all those whom it involves. There appears to be a pervasive sense of failure felt by those close to the suicide victim, even if the relationship was not an intimate one. Certainly, this has been a prevailing reaction in those schools, and/or school districts, in which adolescents and/or pre-adolescents have committed suicide or attempted suicide.

As discussed in the manual, a suicide seems to require an answer to the value of life, and to what in our society is affecting the quality of life to the point that young people, especially, may want to opt out -- permanently and irrevocably. Unfortunately, an attempt at an answer cannot be made with a suicide victim. But our collective need to develop answers has fostered suicide awareness training programs, and preventive interventive approaches which appear to be making a difference.

The development of this training manual is part of this effort. It represents a commitment by the New Jersey State Department of Education to foster greater awareness of this alarming social development within its school systems, and to enable these school systems, through the training of relevant school personnel, to respond sensitively and appropriately before any student becomes a suicide statistic. The educational system in New Jersey is attempting to respond affirmatively, to be active in the solution of the problem, to be part of the answer.

It is hoped that this training manual and its focus on developing greater awareness of the extent of the problem, and the complex interaction of factors involved in adolescent suicide will become a resource for the initiation of effective training programs within all of the school districts of our state. This manual is an introductory effort aimed at heightening awareness, informing and broadening the understanding and perception of relevant school personnel, who then may be able to respond sensitively and readily to youth who are suicidally prone, and fulfill their obligation of linking "high risk" students to appropriate treatment. This manual, by design, does not provide extensive information on more intensive, mental health approaches or treatment of suicidal youngsters as it does not view this as the primary function of a school system. It does view as necessary, however, paying attention to the total child, and providing supportive intervention to young people at risk and to their families.

The manual's emphasis is on doing all that will provide for long term student mental health through the school's identification of at risk students, linking them to appropriate mental health and community resources, working with parents and the community, and with the students themselves in an educational context. It is believed that this kind of an interventive approach is more likely to foster an open, knowledgeable, and caring response from all concerned.

School districts in New Jersey have been confronting an alarming incidence of adolescent suicides, but have had little in the way of training resources and trained school personnel available to intervene early in a preventative manner. The manual has paid particular attention

to the impact on the school community and school personnel of both completed suicides and suicide attempts. It includes approaches and guidelines which, it is believed, will be of help to administrators, nurses, teachers, school guidance personnel, child study teams, and others in dealing with the intense emotions and reactions that usually engulf a school system following an actual suicide. It also specifically presents guidelines for dealing with the return of a student following a suicide attempt, an issue that has been frequently neglected.

Adolescence, as a stage, may be more difficult to negotiate for today's young people, and adults may have a concept of the stresses faced by contemporary adolescents that may be twenty years out-of-date. The pressures of education are more intense, there are greater opportunities for experimentation with drugs and addictive substances, increased pressures for experimenting sexually. However, adolescents, developmentally and emotionally, are not able to cope as readily with these pressures and options.

Added to these accelerated social changes is a sense that the world could be obliterated through nuclear war; that adults are not able to protect them and the world from the chronic social unrest, instability, and mounting violence both interpersonally and in the environment. It should not be surprising then that suicide rates in the 15 to 24 age group have escalated.

Although the suicide rate for 1981 for the 15 to 24 age group in New Jersey is lower than the national rate, we should not "congratulate" ourselves. Rather, one needs to think of each of these suicidal deaths as a possible preventable death. At the same time, the reality is that some youthful suicides may be unpreventable. The issue remains -- can we do more to reduce this incidence to an absolute minimum?

**REFERENCES
AND
BIBLIOGRAPHY**

REFERENCES

1. Data on years 1950 and 1970 secured from Statistical Abstract of United States, U.S. Department of Commerce, 1950 and 1970 Editions.
2. See, for example, Elisabeth Kubler-Ross, On Death and Dying, New York: Macmillan Co., 1968
3. E. S. Shneidman, Ed. Death: Current Perspectives, 2nd Edition, Palo Alto, Calif.: Mayfield Co., p. 432.
4. Statistical Abstract of United States, 1980 Edition, U.S. Department of Commerce.
5. Mortality statistics for 1981 were secured from Health Data Services Division of the Division of Health Planning and Resources Development, New Jersey Department of Health.
6. Marilyn Marshall, "Teen-Age Suicides," Ebony Magazine, Vol. 36, No. 11, Sept. 1981, pp. 36-38.
7. The two models are described in greater detail in L. A. DeSpelder and A. L. Strickland, The Last Dance, Palo Alto, Calif.: Mayfield Co., 1983, pp. 347-352.
8. Karl Menninger, Man Against Himself, New York: Harcourt, Brace, 1938.
9. See Art Kleiner, "How Not To Commit Suicide," CoEvolution Quarterly, No. 30, Summer 1981, pp. 89-109.
10. Data for "Myths and Fallacies" section based on following sources: E. S. Shneidman and N. L. Farberow, PHS Publication No. 852. Wash., D.C.: U.S. Government Printing Office, 1981; M. Griffin and C. Felsenthal, "Teen Suicide: A Cry for Help," Family Circle Magazine, March 1983, pp. 31-34, 68-69; T. C. Barrett, "The Self-Destructive Behavior of Adolescents Seeking Solutions," in In-Service and Resource Guide, Denver, Colo.: Cherry Creek Schools, 1981; and A. L. Matus, Work Based on Experiences in Public Schools.
11. E. S. Shneidman, and N. L. Farberow, Eds. Clues to Suicide. New York: Blakiston Divison, 1957.

BIBLIOGRAPHY

Books, Journal Articles

- * Alavarez, A. The Savage God: A Study of Suicide, New York: Bantam Books, 1973.

- Barrett, T. C. "The Self-Destructive Behavior of Adolescents Seeking Solutions," in In-Service and Resource Guide. Denver, Colo.: Cherry Creek Schools, 1981.

- Babow, I., and Kridle, R. "Problems and Encounters of a Suicidal Adolescent Girl," Adolescence . 7 (28), 1972, pp. 459-478.

- * Caine, E. "Two Contemporary Tragedies: Adolescent Suicide/Adolescent Alcoholism," National Association of Private Psychiatric Hospitals Journal, 9 (3), 1978, pp. 4-11.

- * Cantor, P. "The Adolescent Attempter: Sex, Sibling Position, and Family Constellation," Suicidal and Life-Threatening Behavior, 2 (4), 1972, pp. 252-261.

- * Cantor, P. "The Effects of Youthful Suicide on the Family," Psychiatric Opinion, 12 (6), 1975, pp. 6-11.

- Corder, B.F., Schorr, W., and Corder, R.F. "A Study of Social and Psychological Characteristics of Adolescent Suicide Attempters in an Urban Disadvantaged Area," Adolescence, 9 (33), 1974, pp. 1-6.

- DeSpelder, L.A. and Strickland, A.L. The Last Dance. Palo Alto, Ca.: Mayfield Co., 1983.

- * Domino, G., Gibson, L., Paling, S., and Westlake, L. "Students' Attitudes Towards Suicide," Social Psychiatry, 15, 1980, pp. 127-130.

- Durkheim, E. Suicide: A Study in Sociology. New York: Free Press, 1951.

- * Farberow, N., Ed. The Many Faces of Suicide: Indirect Self-Destructive Behavior. New York: McGraw Hill, 1980.

- Gardner, S. "Suicidal Behavior," Senior Scholastic, Jan. 9, 1981 (Out of Print)

- Garner, H.G. "An Adolescent Suicide, The Mass Media and the Educator," Adolescence, 10 (38), 1975, pp. 241-256.

- Griffin, M. and Felsenthal, C. "Teen Suicide: A Cry for Help," Family Circle Magazine, March 8, 1983, pp. 31-34, 68-69.

*Suggested for purchase or reproduction.

- * Grollman, E.A. Explaining Death to Children. Boston: Beacon Press, 1967.
- * Grollman, E.A. Suicide: Prevention, Interention, Postvention. Boston: Beacon Paperbacks, 1971.
- Hendin, H. Black Suicide. New York: Basic Books, 1969.
- Hendin, H. Suicide in America. New York: W.W. Norton, 1969.
- Hewett, J.A. After Suicide. Philadelphia: Westminster Press, 1980.
- Halinger, P.C. "Violent Deaths Among the Young: Recent Trends in Suicide, Homicide, and Accidents," American Journal of Psychiatry, 136 (9), Sept., 1979, pp. 1144-1147.
- Honig, S. "Ideation in the Art Work of Suicidal Patients," Art Psychotherapy, 2 (1), 1975, pp. 77-85.
- * Hyde, M. Suicide, The Hidden Epidemic. New York: Watts, 1978.
- * Kaplan, H.B., and Pakorny, A.D. "Self Attitudes and Suicidal Behavior," Suicide and Life Threatening Behavior, 6 (1), Spring 1976, pp. 23-35.
- Kenny, T.J., et al. "Visual-motor Problems of Adolescents Who Attempt Suicide," Perceptual and Motor Skills, 48, 1979, pp. 599-602.
- * Klagsbrun, F. Youth and Suicide - Too Young to Die. New York: Pocket Books, 1977.
- Kleiner, A. "How Not to Commit Suicide," CoEvolution Quarterly, No. 30, Summer 1981, pp. 89-109.
- Kubler-Ross, E. On Death and Dying. New York: Macmillan, 1968.
- * Lester, G. and Lester, D. Suicide - The Gamble with Death. Englewood Cliffs, N.J.: Prentice-Hall, 1971.
- Marshall, M. "Teen-Age Suicides," Ebony, Vol. 36, No. 11, September 1981, pp. 36-38.
- Maris, R. W., and Lazerwitz, B. Pathways to Suicide: A Survey of Self destructive Behaviors, Baltimore: The Johns Hopkins University Press, 1981.

*Suggested for purchase or reproduction

- Marks, P.A., and Haller, D.L. "Now I Lay Me Down for Keeps: A Study of Adolescent Suicide Attempts," Journal of Clinical Psychology, 33 (2), April 1977, pp. 390-400.
- * McAnarney, E. R. "Adolescent and Young Adult Suicide in the United States: A Reflection of Social Unrest?" Adolescence, 14 (56), Winter, 1979, pp. 765-774.
- Menninger, K. Man Against Himself, New York: Harcourt Brace, 1938.
- Paulson, M.J., Stone, D., and Sposto, R. "Suicide Potential and Behavior in Children Ages 4 to 12." Suicide and Life-Threatening Behavior, 8:4, Winter, 1978, pp. 225-242.
- * Perlin, S., Ed. A Handbook for the Study of Suicide. New York: Oxford University Press, 1975.
- Rosenkrantz, A.L. "A Note on Adolescent Suicide: Incidence, Dynamics and Some Suggestions for Treatment," Adolescence, 13 (50), Summer 1978.
- * Schuyler, D. "When Was the Last Time You Took a Suicidal Child to Lunch?" Journal of School Health, 43 (8), 1972, pp. 655-657.
- * Scriptographic Booklet. About Suicide. South Deerfield, Mass.: Channing L. Bete Co., 1981.
- * Scriptographic Booklet. Understanding Adolescence. South Deerfield, Mass.: Channing L. Bete Co., 1981.
- Shneidman, E. and Farberow, N.L., Eds. Clues to Suicide. New York: Blakiston Div., 1957.
- * Shneidman, E., Deaths of Man. New York: Quadrangle Books, 1973.
- Shneidman, E., Ed. Essays in Self-Destruction. New York: Jason Aronson, 1967.
- Shneidman, E. and Farberow, N.L. PHS Publication No. 852, Wash. D.C.: U.S. Gov't. Printing Office, 1981.
- Shneidman, E., Ed. On the Nature of Suicide. (Behavioral Science Series) San Francisco: Jossey-Bass, 1969.
- Shneidman, E., Ed. Death: Current Perspectives, 2nd Ed., Palo Alto, Ca.: Mayfield Co., 1980.

*Suggested for purchase or reproduction

- * Simpson, M. The Facts of Death. Englewood Cliffs, N.J.: Prentice-Hall, 1979.
- Sonbrier, J.P. and Vedrinne, J., Eds. Depression and Suicide - Aspects Medical, Psychological and Sociocultural, New York: Pergamon Press, 1983. (Has Chapter by Dr. Abraham Matus.)
- Statistical Abstract of United States, U.S. Dept. of Commerce.
- Tabachnik, N.D. "Subintentioned Self-Destruction in Teenagers," Psychiatric Opinion, 12 (6), July 1975, pp. 21-26.
- Wekstein, L. Handbook of Suicidology: Principles, Problems and Practice. New York: Brunner/Mazel, 1979.
- "When a Teenager Gets Really Depressed," Changing Times, June, 1982.

Fiction and Biographical Materials

- Arrick, F. Tunnel Vision. New York: Bradbury Press, 1980.
- Guest, J. Ordinary People. New York: Viking Press, 1976.
- Mack, J.E. Vivienne: The Life and Suicide of an Adolescent Girl. Boston: Little, Brown & Co., 1981.
- Schiff, Ken. Passing Go. New York: Dodd, Mead, 1972.

Film Strip

Human Relations Media, Suicide: Causes and Prevention. 1976.

Film or VCR

Coronet Films and Video, Suicide: The Warning Signs. 1983.

*Suggested for purchase or reproduction

SC/pc:l/0634j: